Supreme Court, U.S.
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No.

In The
Supreme Court of the United States

EVELYN S. HARRIS,

Petitioner,

v.

THE STANDARD INSURANCE COMPANY and McNEES, WALLACE & NURICK WELFARE BENEFIT PLAN,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

This case presents the opportunity for the Court to define and apply ERISA's mandate to provide "full and fair review" for handling ERISA disability claims under the Department of Labor regulations amended in 2000 (applicable to disability benefit claims filed on or after January 1, 2002); to resolve conflicts among the circuit courts as to aspects of "full and fair review"; to apply the "higher-than-marketplace" duty imposed on dual-role, conflicted plan administrators under *Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008); and to guide courts in judicial review of plan administrators' conduct in claims determinations, particularly when the violations of ERISA minimum requirements affect the record on review to the prejudice of the claimant.

In order to frame the legal questions distilled from the circumstances in this case, it is necessary to briefly summarize those circumstances. In this case the District Court and Magistrate found no violations of ERISA minimum requirements. The Ninth Circuit Court of Appeals disagreed with only one finding below, and concluded the ERISA fiduciary committed procedural errors by introducing a new reason after the initial denial so that Harris could not respond; nevertheless affirmed the denial, despite numerous other violations;[1] failed to properly consider Harris's additional evidence, which related back to the relevant disability elimination period; affirmed primarily on a single

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[1] 29 C.F.R. §§ 2560.503-1(g)(1)(iii), (h)(2)(ii)-(iii), (h)(3)(i)-(ii), (h)(4), (i)(5), (j)(3), and (m)(4), (8).

medical record during that period, taken out of context, and ignored overwhelming contradictory evidence; failed to mention *Glenn* and to provide any meaningful weighing of factors required by *Glenn*; and applied, without reasoning, a deferential abuse of discretion standard of review.

Against this background, Harris's petition presents the following questions:

1. Do the ERISA statutes and Department of Labor amended regulatory requirements to provide a benefit claimant a full and fair review impose upon plan administrators and insurers a duty to disclose information developed during the pre-suit claim process?

2. Do the substantive violations of ERISA statutes (29 U.S.C. § 1133) and Department of Labor regulations, which impaired the development of the claims record, justify affording a substantive remedy to the benefit claimant on the merits or procedural remedies to correct the effects of the violations?

LIST OF PARTIES

The parties to this action are all listed in the caption: The Petitioner, Evelyn Harris, was plaintiff and appellant in the courts below. Respondents Standard Insurance Company and McNees Wallace & Nurick Welfare Benefit Plan were defendants and appellees.

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STATEMENT OF JURISDICTION

This Court's jurisdiction is invoked under 28 U.S.C. §1254(1). The initial subject matter jurisdiction was based on 29 U.S.C. §§ 1132(c)(1) and (f) , and 28 U.S.C. § 1331, as this matter arose under the Employee Retirement Income Security Act (ERISA), a federal law. The Ninth Circuit had jurisdiction under 28 U.S.C. § 1291.

The Ninth Circuit issued its opinion on March 25, 2009. Harris did not seek rehearing.

STATUTES AND REGULATIONS INVOLVED

Title 29, United States Code, Section 1104(a)(1) provides: "[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries" . . . . (D) in accordance with the documents and instruments governing the plan".

Title 29, United States Code, Section 1133(1) provides: "[E]very employee benefit plan shall—(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant."

Title 29, United States Code, Section 1133(2) provides: "[E]very employee benefit plan shall—afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim".

Title 29, Code of Federal Regulations, Section 2560-503-1(g)(1)(iii) (notice of additional information needed to perfect claim), App. 41a.

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Title 29, Code of Federal Regulations, Section 2560-503-1(m)(8) (defining "relevant"), App. 44a.

STATEMENT OF THE CASE

1. The Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, *et seq.*, was enacted to "protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of [those] plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). ERISA requires plan fiduciaries to act "solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries . . . ."; 29 U.S.C. § 1104(a)(1)(A)(i). As part of ERISA's comprehensive enforcement scheme, Section 1132(a)(1)(B) authorizes a plan participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B).

2. This Court has noted that, while Congress derived fiduciary standards from trust law, *Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2343, 2348, 171 L. Ed. 2d 299 (2008); *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 110-15 (1989), Congress also enacted ERISA because trust law did not offer completely satisfactory protection. *Varity Corp. v. Howe,* 516 U.S. 489, 497 (1996). Thus, in view of ERISA's purposes, the Court enforces ERISA by holding plan fiduciaries to a special duty of loyalty to plan participants and beneficiaries in making benefit determinations. *Glenn,* at 2347-48. The fiduciary duty governs claims administration as well as administration of plan assets. *See* 29 U.S.C. § 1002(21)(A) (granting or denying benefits entails

exercise of discretionary authority). Notably, in creating ERISA, Congress's Conference Committee Report said: "The conferees expect that the courts will interpret this prudent man rule (and the other fiduciary standards) bearing in mind the special nature and purposes of employee benefits plans." *See* H.R. Rep. No. 93-1280, at 302 (1974) (Conf. Rep.), as reprinted in 1974 U.S.C.C.A.N. 5038, 5083.

3. In *Firestone,* this Court relied on the purposes of ERISA and its basis in trust law to determine the appropriate standard of review in an action to recover benefits under an ERISA plan. *Id.* at 108-115. The Court concluded "that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case abuse-of-discretion review applies. *Id.* at 115. The Court noted, however, that more searching review is necessary in the case of a conflicted decisionmaker: "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (quoting *Restatement (Second) of Trusts* § 187, comment d at 403 (1959)).

4. Again based on Congress's intent and purposes in enacting ERISA, the Court in *Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008) declared that plan administrators are held to a standard of duty to participants and beneficiaries that is higher than the duty of a non-ERISA insurer to its insured:

ERISA imposes higher-than-

> marketplace quality standards on insurers. It sets forth a special standard of care upon a plan administrator, namely, that the administrator "discharge [its] duties" in respect to discretionary claims processing "solely in the interests of the participants and beneficiaries" of the plan, § 1104(a)(1); it simultaneously underscores the particular importance of accurate claims processing by insisting that administrators "provide a 'full and fair review' of claim denials," *Firestone*, 489 U.S., at 113 . . . (quoting § 1133(2)); and it supplements marketplace and regulatory controls with judicial review of individual claim denials, *see* § 1132(a)(1)(B).

Id., 128 S. Ct. at 2350.

5. This Court and lower courts agree that a uniform body of ERISA law is necessary to provide guidance on review of ERISA benefit decisions. *See, e.g., Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987) (ERISA fiduciary's responsibilities are established by a uniform administrative scheme, providing standard procedures to guide claims processing and benefit disbursement). In fact, the ERISA regulations create minimum procedural standards for claims processing and benefits payments. 29 C.F.R. 2560-503.1(a) specifically provides: "this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries". As the Department of Labor stated in its Final Regulation, *Employee Retirement Income*

Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure, 65 Fed. Reg. 70246 (November 21, 2000):

> This document contains a final regulation revising the minimum requirements for benefit claims procedures of employee benefit plans covered by Title I of the Employee Retirement Income Security Act of 1974 . . . . The regulation establishes new standards for the processing of claims under . . . plans providing disability benefits . . . . The new standards are intended to ensure more timely benefit determinations, to improve access to information on which a benefit determination is made, and to assure that participants and beneficiaries will be afforded a full and fair review of denied claims.[2]

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[2] The Department of Labor stated: "The Department's intentions in including [paragraph (l)] in the proposal were to clarify that **the procedural minimums of the regulation are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference**. . . . Inasmuch as the regulation makes **substantial revisions in the severity of the standards imposed on plans, we believe that plans should be held to the articulated standards as representing the minimum procedural regularity that warrants imposing an exhaustion requirement on claimants.** In the view of the Department, the standards in the regulation represent essential aspects of the process to which a claimant should be entitled under section 503 of the Act. **A plan's failure to provide procedures consistent with these standards would effectively deny a claimant access to the**

6. Plan administrators must follow the rules' explicit procedures for matters including giving notice, reporting, and claims processing. *E.g.*, 29 U.S.C. § 1021(a) (disclosure to all plan participants); *id.* § 1021(b) (reporting requirements); *id.* § 1133 (claims procedures); 29 C.F.R. § 2560.503-1 (same).

7. But this Court has not spoken on the meaning and implementation of the ERISA regulations, which create the standard minimum procedures for full and fair review, to guide claims processing and benefits disbursement. Nor has the Court indicated what remedies are available for violations of these minimum requirements, especially when the violations prejudice the claimant and impair the record on review. The questions framed here involve whether courts must provide greater, more substantive, if not less deferential review of conflicted plan administrators' adverse benefits determinations when they violate the minimum requirements of ERISA procedures to the claimant's prejudice, and what remedies are due to claimants who are the victims of an improper adverse benefits decision.

8. Petitioner Evelyn Harris was an estate law

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administrative review process mandated by the Act. Claimants should not be required to continue to pursue claims through an administrative process that does not comply with the law. At a minimum, claimants denied access to the statutory administrative review process should be entitled to take that claim to a court under section 502(a) of the Act for a full and fair hearing on the merits of the claim." *Id.* at 70255-56 (emphasis added). "By establishing a more complete, **uniform set of minimum requirements** the regulation will reduce the complexity of claims processing requirements, thereby increasing efficiency." *Id.* at 70260 (all emphasis added).

attorney and partner at the Pennsylvania law firm, McNees Wallace & Nurick (March 1, 2001-July 31, 2002) and a participant in the Respondent McNees Wallace & Nurick Plan, of which Standard Insurance Company is the plan administrator. Harris consulted Dr. Megan Borror in October 2001, regarding symptoms of pain, chronic fatigue, and cognitive issues. Harris consulted Dr. Jacob Teitelbaum on December 23, 2002, for the same issues. She stopped working on June 28, 2002.

9. On January 25, 2003, Harris filed a claim for long term disability benefits. App. 85a. Dr. Teitelbaum prepared an Attending Physician Statement (APS) identifying diagnoses causing disability, including chronic fatigue syndrome, pain, and cognitive dysfunction. App. 86a. Harris stated June 28, 2002, as her date of disability because of "fatigue, cronic [sic] pain, reduced ability to concentrate". *Id.*

10. In reviewing Harris's submission, Standard Disability Claims Specialist Steven Poindexter obtained a record review from physician-consultant Dr. Sheila Ingram. Dr. Ingram "recommend[ed] obtaining any psychiatric or neurocognitive testing records if present", thus noting that the file lacked any neuropsychological evaluations, which would address the cognitive issues. App. 87a.

11. Standard denied the claim in a letter by Poindexter dated April 25, 2003. App. 45a-49a.

12. Contrary to 29 C.F.R. § 2560-503-1(g)(1)(iii), the April 25, 2003 letter did not mention the reviewer's specific request for a neuropsychological evaluation as "additional information" necessary to perfect the claim. *See*

App. 87a ("I recommend obtaining any psychiatric or neurocognitive testing records if present").

13. Contrary to 29 C.F.R. § 2560-503-1(j)(3), the denial letter did not notify Harris "in a manner calculated to be understood by the claimant" that she was entitled to receive, on request and free of charge, access to and copies of all documents, records, and other information relevant to her claim.

14. Though Harris did not have a copy of the claim file, including Dr. Ingram's recommendation to obtain any neuropsychological evaluations, Harris's husband, Norman Hessel, a Northwestern Mutual agent with experience selling disability coverages, submitted her appeal.

15. Contrary to 29 C.F.R. § 2560.503-1(h)(3)(ii), Standard presented the appeal to the same claims analyst (Poindexter) and physician-consultant (Ingram) who examined the original claim.

16. Poindexter issued a second denial dated September 24, 2003 ("interim denial letter"). App. 50a-55a. It is undisputed that this interim denial letter violated procedural regulations by stating a new reason for denial, App. 3a: that Harris failed to provide documentation of cognitive problems with a neuropsychological evaluation, which Standard opined one would expect in order to satisfactorily demonstrate neurocognitive impairment sufficient to impair work ability. App. 53a. The letter meets the definition of an "adverse benefit decision" under 29 C.F.R. § 2560.503-1(m)(4), as the Ninth Circuit implied. But importantly, the letter did not offer the further right to appeal this new adverse benefit decision. Thus, this second or new adverse decision, contrary to 29 C.F.R. § 2560.503-1(g), (h)-(j), and (m),

failed to meet every minimum procedural requirement regarding full and fair review and notice of the right to appeal.

17. So, without any further appeal, on October 23, 2003, Benefits Review Specialist Mark Sampson of Standard's Quality Assurance Unit (Standard's Appeal Unit) issued the final denial letter, also noting the absence of neuropsychological testing, which Sampson said undermined the legitimacy of Harris's complaints. App. 56a-59a.

18. Contrary to 29 C.F.R. § 2560.503-1(g)(1)(iii), deposition testimony of Standard's Poindexter and Sampson demonstrated a company-wide practice and procedure, despite ERISA regulation training, of disregarding the regulation's requirement to describe additional information necessary to perfect the claim along with an explanation of why that information would be necessary. Poindexter and Sampson testified that this advice was not their responsibility. App. 73a-81a.

19. On judicial review of Standard's conduct in denying the claim, the Magistrate found it "troubling . . . that Standard did not act on Ingram's recommendation to obtain records of any psychiatric or neurocognitive tests, . . . in its April 23 letter." App. 28a. He concluded, however, that Standard provided full and fair review because the interim letter preceded the review required by the regulations and therefore "Standard was not required to issue the Section 503-1(j)(3) notification statement in *advance* of the statutorily prescribed review." App. 26a. The Magistrate granted Standard's motion to strike Harris's additional evidence relating back to the relevant 180-day

elimination period for determining her disability. App. 33a-35a.

20. On Harris's motion to reconsider and revise the Magistrate's decision, the District Court adopted the Magistrate's Findings and Recommendation to dismiss the claim, affirming Standard's denial. App. 5a-6a. The District Court sustained the Magistrate's ruling granting Respondents' motion to strike and excluded the following evidence offered by Harris:

- neuropsychological testing by Dr. Sandman, documenting significant ongoing cognitive problems during the elimination period, App. 82a-83a ;
- Dr. Teitelbaum's declaration responding to Standard's reasons for denial and relating Harris's cognitive and other symptoms back to the time before his treatment (the elimination period), App. 60a-61a;
- Harris's declaration explaining her disability specifically and in detail, and that she did not know her rights regarding her claim until after the administrative record was closed, App. 62a-66a; and
- Hessel's declaration providing his understanding, based on the information Standard had given him but without the information it withheld, of the claim and appeal. App. 67a-72a.

The District Court did not comment on the Magistrate's conclusion that Standard made no significant violations of ERISA.

21. On Harris's appeal to the Ninth Circuit, without oral argument, the Court of Appeals affirmed in a short unpublished Memorandum, App.

1a-4a. The Court concluded that Standard committed procedural violations in the September 24, 2003 interim denial letter by including new explanations for the denial without giving Harris an opportunity to submit additional evidence to address those explanations. App. 3a. But the Court concluded none of the violations "Standard may have committed . . . amount to the 'wholesale and flagrant violations' required for de novo review." App. 2a-3a. The Court observed that the District Court should have weighed the violations as a factor in reviewing for abuse of discretion. The Court stated that it was considering Harris's newly submitted evidence, which it was the first to do. However, contrary to *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008), the Court of Appeals credited one statement in Dr. Borror's records (just as the District Court had done) over later-acquired evidence of disability directly on point during the relevant period. App. 3a-4a. In this respect, the Ninth Circuit erred dramatically by misunderstanding Dr. Borror's record, which clearly pertained only to Harris's depression and not to the combination of conditions rendering Harris unable to work. App. 87a. The Court concluded Standard did not abuse its discretion in denying benefits, and affirmed the District Court.

22. The Ninth Circuit's ruling illustrates a conflict among the circuits as to whether a plan administrator is obligated to share information collected during the appeal with the claimant. *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005); *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 870, 872-73 (9th Cir. 2008); *Booton v. Lockheed Medical Benefit Plan*, 110

F.3d 1461, 1463 (9th Cir. 1997). *But see Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161, 1167-68 (10th Cir. 2007); *Glazer v. Reliance Std. Life Ins. Co.*, 524 F.3d 1241, 1245-1246 (11th Cir. 2008).

23. A conflict also exists regarding the substantive remedies to which a claimant is entitled when the plan administrator has committed substantive violations, impairing the development of the claims record, of ERISA statutes (29 U.S.C. § 1133) and Department of Labor regulations. Specifically, the circuits divide over whether the reviewing court must allow additional evidence to supplement the impaired record and to what extent. *Saffon*, 522 F.3d at 872-73; *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 970 (9th Cir. 2006) (en banc) (district court may consider evidence outside the administrative record to decide any conflict of interest; noting conflict in circuits).

REASONS FOR ALLOWING THE WRIT

This case presents the Court with the opportunity to resolve and provide guidance on the meaning of the "higher-than-marketplace"[3] obligations imposed under ERISA statutes and regulations in the plan administrator's performance of the duty to conduct full and fair review of an adverse benefits decision, and to provide notice of the right to appeal that decision. It offers the Court an opportunity to provide guidance on what follows when procedural violations of the ERISA statute or Department of Labor impair the development of the

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[3] *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2350, 171 L. Ed. 2d 299 (2008).

record, prejudicing a claimant. These questions arise frequently in litigating ERISA claims and transcend decisions regarding the applicable standard of review recently articulated in *Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008).

The Ninth Circuit's decision in this case presents two conflicts between the circuits: (1) the obligations of an ERISA plan or insurer to disclose information pre-suit (*Abram v. Cargill, Inc.,* 395 F.3d 882, 886 (8th Cir. 2005); *Saffon v. Wells Fargo & Co. Long Term Disability Plan,* 522 F.3d 863, 870, 872-73 (9th Cir. 2008); *Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). *But see Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161, 1167-68 (10th Cir. 2007); *Glazer v. Reliance Std. Life Ins. Co.*, 524 F.3d 1241, 1245-1246 (11th Cir. 2008)); and (2) whether and to what extent the reviewing court should admit additional evidence beyond the administrative record (*Saffon,* at 870-73; *Booton,* at 1463; *Abatie v. Alta Health & Life Ins. Co.,* 458 F.3d 955, 970 (9th Cir. 2006) (en banc) (circuits cited therein)). These conflicts call for this Court's review under this Court's Rule 10(a).

Moreover, the Court should grant certiorari because the Ninth Circuit decided important questions of federal law that this Court has not addressed (Rule 10(c))—namely, how the 2000 regulations implementing ERISA satisfy ERISA's mandate for full and fair review—and because the Ninth Circuit's decision so far departs from the accepted and usual course of judicial proceedings, and sanctions such a departure, as to call for this Court to exercise its supervisory power. Rule 10(a). In granting certiorari and exercising its supervisory

power, the Court should amplify and implement its holding and the Department of Labor's intent that our judicial system must follow a uniform procedure and method in reviewing ERISA benefits claim decisions.

What occurred here presents precisely the problem with the absence of such a judicial system. The Magistrate and the District Court erred as a matter of law in ruling that Standard reached its interim decision before the "full and fair review" process required by the ERISA regulations, and that therefore the interim decision did not trigger full and fair review.

This interpretation of the law and the applicability of the Department of Labor regulations defies logic. The Ninth Circuit correctly reversed that aspect of the District Court's Order by recognizing the interim letter could only be an adverse benefit decision, but then abandoned the ERISA statutes' and Department of Labor's minimum requirements flowing from that conclusion: that is, Standard committed clear violations of 29 C.F.R. § 2560.503-1(g)(1)(iii) (which it admitted it does not follow); 29 C.F.R. § 2560.503-1(h)(2)(iii), (h)(4), (h)(3)(i), (j)(3), and (m). The impact of those violations, as explained here, impaired the record so severely as to prejudice Harris and eviscerate ERISA's mandates. The Ninth Circuit, in its stunted and contradictory analysis of ERISA statutes and regulations, also improperly and inadequately weighed, or failed to weigh, the violations along with Harris's additional evidence, or to give Harris an opportunity to supply the needed information to support her claim, so that she could rectify the record impaired by the ERISA violations.

In essence, the decision points to the unsettled nature of the meaning of full and fair review based on "higher-than-marketplace" standards applied to ERISA plan administrators, and the remedies for violations of the full and fair review obligations. Harris asks the Court to accept review of the legal errors made by the lower courts in order to remedy the great injustice done to her and to prevent this injustice from affecting other claimants who, by the gap in directions for judicial review, are left to the discretion of conflicted, biased ERISA plan administrators. The Court should address and resolve the above questions in accordance with ERISA's mandates. For all these reasons, the *Harris* decision merits this Court's review.

I. THE CONFLICTS ILLUMINATED BY *HARRIS* MERIT THIS COURT'S REVIEW.

A. The Circuits Conflict Over The Obligations Of An ERISA Plan Or Insurer To Disclose Information Pre-Suit.

The Ninth Circuit's ruling in this case illustrates a conflict among the circuits as to whether a plan administrator is obligated to share information collected during the appeal with the claimant. In *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005), interpreting the regulations for full and fair review before they were amended, 29 C.F.R. § 2560.503-1(h)(2000), the Eighth Circuit held:

> Full and fair review includes the right to review all documents, records, and other information relevant to the

claimant's claim for benefits, and the right to an appeal that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim. 29 C.F.R. § 2560.503-1(h)(2000). This circuit has held that these procedures allow a claimant to "adequately prepare herself for any further administrative review, as well as an appeal to the federal courts. The statute and the regulations were intended to help claimants process their claims efficiently and fairly." . . . "The persistent core requirements" of full and fair review include "knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision." *Grossmuller v. Int'l Union, UAW*, 715 F.2d 853, 858 n.5 (3rd Cir. 1983). ERISA and its accompanying regulations essentially call for a "meaningful dialogue between the plan administrators and their beneficiaries." *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). Plan procedures cannot be "full and fair" without providing for this communication. *See Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617, 620 (8th Cir. 1998) (holding that ERISA

> claimants are entitled to "timely and specific" explanation of benefit denials, and may not be "sandbagged" by post-hoc justifications of plan decisions).[4]

Abram relied on the Ninth Circuit's decision in *Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997), followed more recently by *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 870-73 (9th Cir. 2008). *Saffon* and *Booton* require disclosure of material developed pre-suit, as part of the "meaningful dialogue" guaranteed by ERISA. Interpreting the pre-amendment regulation (29 C.F.R. § 2560.503-1(f)(2000)), *Booton* held:

> In simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries. If benefits are denied in whole or in part, the reason for the denial must be stated in reasonably clear language,

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[4] *But see Midgett v. Wash. Group Int'l Long Term Disability Plan*, 561 F.3d 887, 896 (8th Cir., April 15, 2009) (based on amendments applicable to disability benefit claims filed on or after Jan. 1, 2002, 29 C.F.R. 2560.503-1(h)(3)(iii), (i)(5), (j)(3), (j)(4), (j)(5). m(8), "the full and fair review to which a claimant is entitled under 29 U.S.C. § 1133(2) does not include reviewing and rebutting, prior to a determination on appeal, the opinions of peer reviewers solicited on that same level of appeal"). A conflict continues to exist between the Tenth and Eleventh Circuits, and the Ninth Circuit (disclosure through meaningful dialogue, implementing Department of Labor's intent, *see* n. 2, *supra*). In the amendments, the Department of Labor clearly made the minimum standards more stringent, not less. The reasoning in *Abram* remains sound, though *Midgett* essentially joins the Tenth and Eleventh Circuit in this conflict.

> with specific reference to the plan provisions that form the basis for the denial; **if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it.** There is nothing extraordinary about this; it's how civilized people communicate with each other regarding important matters.
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> * * *
>
> . . . [T]o deny the claim without explanation and without obtaining relevant information is an abuse of discretion. . . . *cf. Halpin* v. *W.W. Grainger, Inc.*, 962 F.2d 685, 691 (7th Cir. 1992)(an ERISA plan cannot rely on a lack of information to support its denial of benefits when it fails to inform the beneficiary about the missing information so that the beneficiary can provide it).

Id. at 1463 (emphasis added).

In *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 870-73 (9th Cir. 2008), the court elucidated the meaning of "meaningful dialogue" where, as here and in many other instances, the plan administrator adds a new reason for the benefits denial. In that frequently-occurring event, the district court reviewing the denial must give the claimant an opportunity to present evidence on the newly-raised reason, that is, "objective evidence of whether she is totally disabled under the terms of the Plan." *Id.* at 872-73. Next, in determining the degree of deference to which the

plan administrator is entitled on judicial review, the district court must consider the course of dealing with the claimant. *Saffon* holds that a plan administrator violates its duty to have a meaningful dialogue with its beneficiary by means of precisely the same tactics Standard used here: opaque communications and taking Dr. Borror's statement out of context or otherwise distorting in an apparent effort to support denial (citing John H. Langbein, *Trust Law as Regulatory Law,* 101 Nw. U. L. Rev. 1315, 1319 (2007), an authority followed by this Court in *Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008), noting a physician claims reviewer's allegation "that he was instructed 'to use language to support the denial of disability insurance'; that he was not allowed 'to request further information or suggest additional medical tests'; and that he was 'not supposed to help a claimant perfect a claim'"). Finally, *Saffon* holds that after determining the degree of deference (if any) it should accord the insurer's decision, the district court must take into account such additional evidence as the claimant may present and any contrary evidence the insurer may present. The court warned, however, that the admission of significant new evidence will require *de novo* reconsideration of the decision.

But the Tenth and Eleventh Circuits disagree. In *Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161, 1167-68 (10th Cir. 2007), interpreting the amended regulation, the Court reasoned that requiring a plan administrator to grant a claimant the opportunity to review and rebut medical opinions generated on administrative appeal "would set up an unnecessary cycle of submission, review, re-

submission, and re-review", which "would undoubtedly prolong the appeal process" (citing 29 C.F.R. § 2560.503-1(i)(3)(i)). The Eleventh Circuit held in accord with the Tenth in *Glazer v. Reliance Std. Life Ins. Co.*, 524 F.3d 1241, 1245-1246 (11th Cir. 2008).

The *Harris* decision illuminates this conflict. The Court recognized the undisputed procedural violations Standard committed, particularly by "including new explanations for its denial of benefits in the 'interim' denial letter of September 24, 2003, without giving Harris an opportunity to then submit additional evidence relevant to those explanations." App. 3a. The Court even cited *Saffon* and *Abatie*. App. 3a. Nevertheless, the Court overlooked that the record showed numerous egregious violations underlying the only violation it identified:

1. Standard's failure to share its reviewer's specific recommendation and request for any neuropsychological evaluation because a neuropsychological evaluation was necessary to perfect the claim. The Ninth Circuit could not have more clearly identified this as a violation in *Saffon*, at 873, relying on Langbein's note that a physician consultant "was not allowed 'to request further information or suggest additional medical tests'; and that he was 'not supposed to help a claimant perfect a claim'". The Magistrate found this violation only "troubling", and excused it as not amounting "to a procedural violation" because "Standard was not required to provide an exhaustive list of every possible piece of medical evidence that could conceivably strengthen Harris' application"; because he believed Harris had an opportunity to supplement the

administrative record before the final decision; and because there was no suggestion in the record that "psychiatric or neurocognitive testing might have significantly modified the conclusions Standard drew from these facts." App 30a. The Ninth Circuit disagreed, correctly calling Standard's conduct what it was: a violation identical to that outlawed in *Saffon*, 522 F.3d at 871-73, and *Abatie*, 458 F.3d at 970. App. 3a.

2. Standard's failure to notify Harris in the first denial letter of this specific additional information necessary to perfect her claim, in violation of 29 C.F.R. § 2560.503-1(g)(1)(iii).
3. Standard's admission that it routinely disregards the additional information regulation, 29 C.F.R. § 2560.503-1(g)(1)(iii).
4. Standard's submission of the review to the same analyst and medical examiner as in the initial review. 29 C.F.R. § 2560.503-1(h)(3)(ii) and (v).
5. Standard's failure to identify the medical experts "whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination". 29 C.F.R. § 2560.503-1(h)(3)(iv).
6. Standard's failure in the interim and final denial letters to notify Harris that she had a right to request and obtain the claim file which would have revealed the request and need for a neuropsychological evaluation. 29 C.F.R. § 2560.503-1(j)(3).
7. Standard's selective emphasis, if not sole reliance, on Dr. Borror's report that Harris's depression had "markedly improved" (in Standard's words): Magistrate's decision, App.

13a; April 25, 2003 denial, App. 46a, 47a; Sept. 24, 2003 interim letter, App. 54a), knowing that a neuropsychological evaluation might have illuminated the contradiction between that statement and Dr. Teitelbaum's pre-suit information (which Standard rejected). This error conflicts directly with this Court's decision in *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2352, 171 L. Ed. 2d 299 (2008). Ironically, the Ninth Circuit believed Dr. Borror's notation of improvement related to Harris's disability based on all her diagnoses and symptoms (*e.g.*, pain, fatigue, cognitive problems), App. 4a, despite the fact that Dr. Borror clearly indicated to the contrary that it pertained only to Harris's depression. App. 87a.

Standard did not do any of the required acts in the first, interim (second) and final adverse benefit decision letters. These procedural violations not only identify a conflict in the circuits but also require a substantive remedy as to which there is another conflict in the circuits: whether and to what extent the reviewing court should allow additional evidence to supplement and correct the record impaired by the above violations.

In the event that the writ is allowed, Harris will argue that the ERISA statute and Department of Labor regulations' requirements to provide a benefit claimant a full and fair review impose upon plan administrators and insurers a duty to disclose information developed during the pre-suit claim process, along with an opportunity to respond. If ERISA plans or their insurers violate these requirements, then it is up to the District Court to take additional evidence to complete the record.

B. The Circuits Conflict Over Whether And To What Extent The Reviewing Court Should Admit Additional Evidence Beyond The Administrative Record.

In *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 970 (9th Cir. 2006) (en banc), the Ninth Circuit held: "The district court may, in its discretion, consider evidence outside the administrative record to decide the nature, extent, and effect on the decision-making process of any conflict of interest; the decision on the merits, though, must rest on the administrative record once the conflict (if any) has been established, by extrinsic evidence or otherwise." The Court noted the conflict in the circuit courts:

> Many circuits limit a district court to the administrative record when the court is reviewing a case on the merits for an abuse of discretion; consideration of new evidence is permitted only in conjunction with *de novo* review of a denial of benefits. *See Urbania v. Cent. States, Se. & Sw. Areas Pension Fund*, 421 F.3d 580, 586 (7th Cir. 2005) . . . [*Kosiba v. Merck & Co.*, 384 F.3d 58, 67 n.5 (3d Cir. 2004)], (noting that, "in general, the record for arbitrary-and-capricious review of ERISA benefits denial is the record made before the plan administrator"), [*cert. denied*, 544 U.S. 1044 . . . (2005)]); [*Fought v. Unum Life Ins. Co. of Am.*,

> 379 F.3d 997, 1003 (10th Cir. 2004)] (noting that courts are limited to the administrative record when reviewing for abuse of discretion); *Zervos v. Verizon N.Y., Inc.*, 252 F.3d 163, 173 (2d Cir. 2001) (noting that when review is for abuse of discretion, the record consists of the administrative record); *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 608 &n.6 (4th Cir. 1999) (noting that on *de novo* review, a court may consider extra-judicial evidence, but stating that abuse of discretion review must be based on the evidence before the administrator); [*Vega v. National Life Ins. Servs.*, 188 F.3d 287, 300 (5th Cir. Tex. 1999)] (restricting review to the administrative record when the court is considering the administrator's factual determinations for abuse of discretion); *Buckley v. Metro. Life*, 115 F.3d 936, 941 & n.2 (11th Cir. 1997) (per curiam) (holding that extra-record evidence, presented to the district court on review for abuse of discretion, was irrelevant).

As of the writing of this Petition, none of these decisions cited in *Abatie* as conflicting on this issue have been since overruled or modified.

This conflict presents the opportunity for the Court to decide that substantive violations of ERISA statutes (29 U.S.C. § 1133) and Department of Labor regulations, which impair the development of the claims record, justify allowing additional evidence as necessary to correct the deficient record.

II THIS COURT SHOULD EXERCISE ITS SUPERVISORY POWER TO DECIDE IMPORTANT QUESTIONS OF FEDERAL LAW AS TO WHETHER FULL AND FAIR REVIEW REQUIRES THE REVIEWING COURT TO GIVE MEANINGFUL, ADEQUATE WEIGHT TO UNDISPUTED PROCEDURAL VIOLATIONS

A. There Is A Gap In Important Questions Of Federal Law As To The Mandate For Full And Fair Review.

This Court's recent decision in *Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008) requires weighing of a combination of factors, *id.* at 2351, but it does not indicate how to do this in a manner that implements full and fair review through judicial enforcement of the regulations.

Harris conflicts with *Glenn*. *Glenn* holds that review under heightened scrutiny applicable to a conflicted plan administrator requires a balancing of factors to determine the impact of a conflict on the benefits decision *Id.* at 2351-52. No one factor is determinative except as a tiebreaker. *Id.* at 2351.

The Ninth Circuit in this case failed to follow *Glenn* in several respects: Instead of articulating what combination of factors it weighed, the Court relied on only one factor—the procedural violation of basing a denial on a new reason (lack of a neuropsychological evaluation). As described above, the Court stopped short of acknowledging that this one violation incorporates and triggers a host of other violations. Nevertheless, the Ninth Circuit

concluded, without explanation, that whatever violations Standard may have committed did not rise to the "wholesale and flagrant" level required for *de novo* review. Thus, the *Harris* decision demonstrates that this Court has not determined what degree of violations by a conflicted plan administrator would trigger *de novo* review, or how significant the violations must be to reach even the highest level of skeptical abuse-of-discretion scrutiny.

In addition, *Harris* directly ignores the *Glenn* Court's reliance on the critical "serious concern" arising when, as in this case and *Glenn,* the plan administrator and the reviewing court selectively emphasize (or solely rely on) one medical report while de-emphasizing (or completely ignoring) another. *Glenn* affirmed the Sixth Circuit Court of Appeals' consideration of "[a]ll these serious concerns, taken together with some degree of conflicting interests" on the part of the plan administrator, in setting aside MetLife's adverse benefit decision. *Glenn,* 128 S.Ct. at 2352. But here, the Ninth Circuit either weighed no other factors or concerns that conclusively exist, or inadequately weighed them, in either case neglecting to follow this Court's directives. The Ninth Circuit merely paid lip service to the *Glenn* requirements, undercutting the importance of the higher-than-marketplace standards.

B. The *Harris* Decision's Failure To Conduct A Meaningful Weighing Of Factors Calls For An Exercise Of This Court's Supervisory Power.

The Ninth Circuit's improper analysis here

justifies a grant of certiorari to instruct courts that under *Glenn* and prior law, courts and plan administrators must enforce ERISA's "full and fair review" expressed in its statutory and regulatory mandates. The Court should exercise its supervisory power to settle these crucial questions of federal law affecting all ERISA claimants.

As demonstrated above, by giving inadequate weight to the plan administrator's admitted and uncontradicted violations of the ERISA statute and Department of Labor regulations, which impaired the pre-suit record and prejudiced the beneficiary's claim, the Ninth Circuit failed to enforce full and fair review.

All levels here ignored one factor that alone should have been determinative: the plan administrators' direct admission that they violated, and regularly have a practice and procedure of violating, the 29 C.F.R. § 2560.503-1(g)(1)(iii) requirement to inform the claimant what specific additional information she should provide to assist the plan and the claimant in determining whether she is entitled to benefits (that is, perfect the claim), and why. Neither the review committee, the District Court, nor the Ninth Circuit Court of Appeals considered, much less evaluated the meaning of this fatal fact. Yet no weighing or balancing should be necessary when the plan admits knowing violations of the law or in other ways refuses to meet minimum procedural requirements. In fact, this evidence suggests a pattern and practice within Standard to disregard important Department of Labor regulations, practices reminiscent of Langbein's description of UNUM's misconduct, found only after an external claims audit.

The *Glenn* Court split over the guidelines as to "how" the conflict should "be taken into account on judicial review of a discretionary benefit determination." The plurality chose the "combination of factors" approach, commenting that "any one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor's inherent or case-specific importance. The conflict of interest at issue [in that case], for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, in other words combination-of-factors method of review." *Glenn,* 128 S. Ct. at 2351.

Justice Scalia, dissenting, called for a predictable set of liabilities under uniform standards of primary conduct. He noted that the *Restatement of Trusts* instructs a court to inquire into four categories of abuse of discretion separately, using different measurements. One type of abuse of discretion occurs as follows: a trustee acts unreasonably when their decision is substantively unreasonable either with regard to their exercise of a discretionary power or with regard to their assessment of whether the preconditions to that exercise have been met. *Restatement (Second) of Trusts* § 187, comment i (1959).[5]

Standard's conceded disregard of an external standard, 29 C.F.R. § 2560.503-1(g), among other violations, should be recognized as a blatant abuse of discretion: "the existence or nonexistence, the

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[5] The *Restatement (Third) of Trusts* was issued in 2007; the sections therein pertinent to the above discussion are 50 and 87.

definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee's conduct can be judged". *Restatement,* § 187, comment d. As noted in comment i, "If there is a standard by which the reasonableness of the trustee's judgment can be tested, the court will control the trustee in the exercise of a power where he acts beyond the bounds of a reasonable judgment, unless it is otherwise provided by the terms of the trust." In other words, the violation of an external standard for measuring the decisionmaker's reasonableness, by itself, is a breach of fiduciary duty.

"A reasonable decision is one over which reasonable minds seeking the 'best' or 'right' answer could disagree." *Glenn,* at 2360 (Scalia, J., dissenting). But as noted, where the decisionmaker admits reckless or intentional violation of the external standard of reasonableness, there is no need to weigh factors. The multiple violations of ERISA regulations constitutes abuse of discretion as a matter of law.

In this case, the Ninth Circuit should have recognized that Standard's admission that they directly and regularly violate § 2560.503-1(g)(1)(iii), combined with their numerous violations of the regulations' other minimum required procedures for full and fair review and notice, compounded by the District Court's refusal to consider contemporaneous medical opinions in later-submitted materials, all showed absolute abuse of discretion, or alternatively, as the Court of Appeals put it, "wholesale and flagrant" violations that trigger *de novo* review.

As analyzed by Langbein, the scandalous problems in ERISA insurer Unum's ERISA claims

management can be found in most if not all insurers that are inherently conflicted plan administrators. John H. Langbein, *Trust Law As Regulatory Law: The UNUM/Provident Scandal and Judicial Review of Benefit Denials Under ERISA,* 101 Nw. U. L. Rev. 1315, 1317-21 (2007) (describing UnumProvident's behavior). In this case, though no one has audited Standard to reveal their widespread violations characteristic of Unum, the testimony of Standard claims analysts in this case expressly admits such violations in the form of Standard's company-wide culture, bias, and policy of ignoring the additional information regulation. Moreover, the denial letters on their face prove, and the claims file confirms, the same.

Because ERISA fiduciaries, unlike private trustees who have no stake in the trust corpus, are aligned with the employer or insurer, deference has no place in the context of this conflicted relationship. Thus, in construing ERISA's fiduciary duties, trust principles, which allow discretion and deference, should yield to ERISA's mandates. Granting a writ in this case would allow the Court to substantially clarify and call a halt to conflicted plan administrators' continued violations of ERISA and abuse of the discretion that the law has allowed them thus far, violations that prejudice claimants by impairing the development of the record for reviews.

III. THE COURT SHOULD SETTLE THE QUESTION WHETHER SUBSTANTIVE VIOLATIONS OF ERISA STATUTES (29 U.S.C. § 1133) AND DEPARTMENT OF LABOR REGULATIONS THAT IMPAIR THE

DEVELOPMENT OF THE CLAIMS RECORD JUSTIFY ACCORDING A SUBSTANTIVE REMEDY TO THE BENEFIT CLAIMANT

A. The Ninth Circuit Failed to Meaningfully Consider Harris's Additional Evidence.

The Ninth Circuit was the first court to consider Harris's additional evidence, which she submitted at the District Court level. But the Ninth Circuit erred dramatically by literally and impermissibly finding "Harris submitted no contemporaneous medical evidence of her inability to work for the entirety of the relevant six-month disability waiting period." App. 3a-4a. This decision improperly excluded all evidence other than the one statement in Dr. Borror's records, just as the District Court did, taking that one record out of context just as the District Court did. *See* App. 87a. The Ninth Circuit said it was considering additional evidence but did the opposite. Since the Court did not explain what led it to decide that the additional evidence did not overcome Harris's comment to Dr. Borror on November 5, 2002 that she felt "100% better" (relating only to depression and not ongoing pain, fatigue and cognitive problems), App. 87a, which Standard and the reviewing courts seized upon as fatal to Harris's disability claim, one can only conclude that the Court erred by not meaningfully weighing the additional information under *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 970 (9th Cir. 2006) (en banc) and as implied by *Glenn*. The additional information, adequately considered, amounts to substantial proof of Standard's egregious

bias against finding disability and granting Harris disability benefits. The Court articulated a remedy of allowing additional evidence outside the administrative record but then did not follow through on the remedy by providing Harris to more fully supplement the record. This Court should allow review of *Harris* in order to breathe life into the remedies courts can grant benefits claimants who are denied full and fair review.

The Magistrate granted Standard's motion to strike all of this additional evidence: a neuropsychological evaluation by Curt Sandman, M.D., reviewing and opining on the relevant disability period; a declaration by Harris's treating physician, Dr. Teitelbaum, who submitted the Attending Physician Statement supporting her original claim; Harris's own declaration and that of her husband explaining how they supported her claim in reliance on Standard's misleading claims handling. The Magistrate struck these materials on the ground that they went "strictly to the merits of Standard's benefits decision rather than to establishing conflict of interest, and therefore cannot be admitted pursuant to the conflict of interest exception" articulated in *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 970 (9th Cir. 2006) (en banc). App. 35a. The District Court adopted that reasoning. App. 6a. The Ninth Circuit reversed the grant to strike evidence, but affirmed anyway. App. 3a.

In sum, the Ninth Circuit failed to provide Harris with full and fair review when it selected out a single record and ignored other supporting evidence of Harris's disability during the relevant elimination period, without explaining why or how it

reached this decision. Granting certiorari in this matter will provide the Court a platform for instructing future courts to enforce full and fair review.

B. Enforcement Of ERISA Statutes And Regulations' Mandate For Full And Fair Review Should Also Be Available Through A Grant Of Retroactive Benefits Or Remand To The District Court For *De Novo,* Non-Deferential Review Along With Record Supplementation.

Certiorari is also warranted to respond to the confusion among the circuits and within them as to what a reviewing court should do to remedy a claimant deprived of full and fair review through an adverse benefits decision. The substantive violations of ERISA statutes (29 U.S.C. § 1133) and Department of Labor regulations, which impaired the development of the claims record, justify affording a substantive remedy to the benefit claimant, requiring reversal with a grant of retroactive benefits to Petitioner Harris, or remand to the District Court for *de novo* or non-deferential review and the right to supplement the record addressed above.

The slew of errors the lower courts have sanctioned here demonstrates the need for review by this Court. For a direct, company-wide practice and procedure of violating regulations as Standard admitted here, the remedy should be to deem the benefits denial reversible error at every level of review, as a matter of law.

Short of that, the Court should allow the

Plaintiff the opportunity to develop and the District Courts to admit and consider additional evidence to determine whether the plan fiduciary's benefits determination was proper, regardless of standard of review; allow *de novo* review; and require an order for broader discovery under the merits of the claim.

For improper notice and lack of review, the remedies should be the same. As exemplified here, neither Harris nor any reviewing court could know what additional evidence would have been developed to address the disability determination because (1) Standard never told the claimant what they knew she needed to perfect the claim and they needed to decide the claim; (2) Harris had no opportunity to seek and submit responsive material during the claims process; (3) Standard had no opportunity to consider unknown responsive material because they deliberately closed off any such possibility; (4) the District Court had the opportunity to open and supplement the record but improperly decided not to; and (5) the Ninth Circuit generally cited Harris's on-point additional evidence but did not truly consider and weigh it as required by federal decisional law from this Court and below.

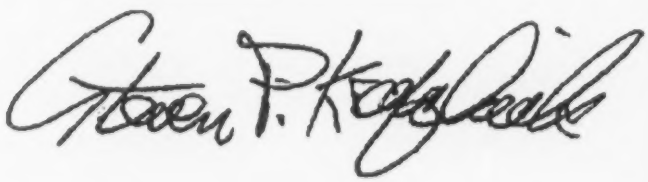
Here, the Court has a clear opportunity to rectify the lower courts' refusal to embrace ERISA's mandates. The Court should address this "perfect storm" of violations which the lower courts improperly allowed and continue to allow insurers to perpetrate on claimants, in direct violation of their higher-than-marketplace fiduciary duties.

CONCLUSION

The lower courts in this case failed to follow the ERISA statutes' and Department of Labor regulations' mandate for full and fair review at every level evaluating an ERISA plan administrator's adverse benefits determination. They failed to follow this Court's direction in *Glenn* that courts must consider and weigh "serious concerns" manifest in the conflict of interest inherent to dual-role plan administrators. Given the pressing issues presented here and the confusion manifest in the lower courts' misguided judicial review, this case merits certiorari.

For all these reasons, Petitioner Evelyn Harris prays that this Court issue a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted,



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